

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11758

11777 **CERTIFICATE OF DEATH**

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		STATE Maryland		COUNTY Talbot			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Easton		LENGTH OF STAY (in this place) 4 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Easton			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 806 Dover Road				STREET ADDRESS (If rural give location) 806 Dover Road			
3. NAME OF DECEASED (Type or Print) Lillian May Brooks				4. DATE OF DEATH (Month) (Day) (Year) Nov. 19 1956			
5. SEX Female		6. RACE OR COLOR White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Nov. 19, 1881	
				9. AGE last birthday 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Rev. Albert C. Hale				14. MOTHER'S MAIDEN NAME Lillian Tabor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS 806 Dover Rd. Miss L. May Brooks, Easton, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH sudden			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic coronary thrombosis				sudden			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 to 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 1:10 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Wm. H. Harrison</i>				ADDRESS (Street, city, town, state) <i>Easton Maryland</i>		DATE SIGNED <i>19 Nov 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 21, 56		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE <i>11-23-56</i>		REGISTRAR'S SIGNATURE <i>Mrs. H. H. Harris</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Frampton Carroll</i>		ADDRESS Easton, Md.	
W. Frampton Carroll, Easton, Md.							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

BUREAU V. 2

NOV 23 1956

RECEIVED

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

File No. _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

REGISTRATION NO. _____

SEX _____

AGE _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

CAUSE OF DEATH _____

MANNER OF DEATH _____

PERIOD OF ILLNESS _____

DATE OF EXAMINATION _____

BUREAU V. 2

NOV 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9 FilmG207 12-3-56 et
CERTIFICATE OF DEATH

11761

Reg. Dist. No. 297

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whittman		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Whittman	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Henry First Middle Last Grace		4. DATE OF DEATH Month 11 Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Grace		14. MOTHER'S MAIDEN NAME Rachel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX XXXX		16. SOCIAL SECURITY NO. XXXXXX	
17. INFORMANT Carrie P Avery, Whittman, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart disease 421.4 DUE TO toxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 12 , 19 56 , to Nov 13 , 19 56 , that I last saw the deceased alive on Nov 12 , 19 56 , and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James M. Reeser, M.D. Nov 13 1956 ACTUAL SIGNATURE QUY M REESER SR PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 / 17 / 56	
22c. NAME OF CEMETERY OR CREMATORY Whittman COM		22d. LOCATION (City, town, or county) (State) Whittman ind.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Deshield, Easton, Md.		24a. REC'D BY REGISTRAR DATE 11-23-56	
24b. REGISTRAR'S SIGNATURE Mrs. C. W. Seth			

W

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>Robert Henry</i></p>		<p>DATE OF DEATH <i>11/18/56</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>AGE <i>68</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF BIRTH <i>10/20/1888</i></p>		<p>PLACE OF BIRTH <i>England</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Retired</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PERMANENT CAUSE <i>Coronary Artery Disease</i></p>		<p>INTERESTING FACTS <i>None</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>DATE <i>11/18/56</i></p>	
<p>SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>DATE <i>11/18/56</i></p>	

BUREAU V. M.

NOV 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11762

11779 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>178-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Greaves</u> Last <u>Greaves</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 19, 1956</u>
9. AGE (In years last birthday) yrs. <u>29</u> Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Emory Greaves</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>111-111-1111</u>	
17. INFORMANT <u>Mumma's</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>7544</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:40 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		DATE SIGNED <u>21 Nov. 56</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>November 21</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peter Church Yard</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thurman E. Newman</u>		ADDRESS <u>500 Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>N.A. Newkirk</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Newkirk</u>	

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BUREAU V. S.

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11789

CERTIFICATE OF DEATH

11763

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton.	c. LENGTH OF STAY IN 1b 30 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton. 40	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 11 South Street.	
3. NAME OF DECEASED (Type or print) First Middle Last Maggie Perry Harding.		4. DATE OF DEATH Month Day Year Nov. 20, 56 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1865 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (In years lost birthday) 91 yrs.
11. BIRTHPLACE (State or foreign country) Caroline County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Newton N. Andrew.		14. MOTHER'S MAIDEN NAME Elizabeth Griffin.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss. Lelah Perry.		Address Easton.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 hrs. Yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalopathy due to Cerebral Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 49 , to 11/19 , 19 56 , that I last saw the deceased alive on 11/19 , 19 56 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md DATE SIGNED 11/20/56			
ACTUAL SIGNATURE Shepard Jr M.D.		DATE SIGNED 11/20/56	
PHYSICIAN'S NAME (Type) SHEPARD KRECH JR			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Nov. 23, 56	22c. NAME OF CEMETERY OR CREMATORY Spring Hill	22d. LOCATION (City, town, or county) (State) Easton. Md
23. FUNERAL DIRECTOR'S SIGNATURE Shepard Jr		24a. REC'D BY REGISTRAR DATE 11/23/56	24b. REGISTRAR'S SIGNATURE N.H. Neukirch

CERTIFICATE OF DEATH

NAME OF DECEASED		MARRIAGE	
AGE		DATE OF BIRTH	
SEX		RACE	
EDUCATION		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

DEC 3 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

11764
290

11781

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>23 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>E</u> Last <u>Headley</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 20 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Colas Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Thrift</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Myrtle H. Fletcher - daughter - Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic coronary disease</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>11/5/56</u> , 19 <u>56</u> , to <u>11/5/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/5/56</u> , 19 <u>56</u> , and that death occurred at <u>12:14 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Totuskey, Virginia</u>		22d. LOCATION (City, town, or county) (State) <u>WARSAW, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>PRESTON, MD</u>				24a. REC'D BY REGISTRAR DATE <u>11/8/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

DECEASED

PLACE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

BUREAU V. S.

NOV 14 1956

RECEIVED

11782 CERTIFICATE OF DEATH

Reg. Dist. No. 296

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>17hr 55min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Linden Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Dee</u> Last <u>Heinmuller</u>				4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-52</u>		9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Ernest J. Heinmuller</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest Heinmuller</u> Address <u>Easton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>343X</u> DUE TO <u>Cerebral Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Possible encephalitis</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Pulmonary edema</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>3:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>2195 Washington Street</u> DATE SIGNED <u>23 Nov 56</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				<u>Easton, Md, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR DATE <u>11/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newen</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11766

11783

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown - Md.</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>178-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>R. Norman</u> Middle <u>R.</u> Last <u>Hitch</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R. Hitch</u>		14. MOTHER'S MAIDEN NAME <u>Anna Claybille</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-16-945</u>	
17. INFORMANT <u>Ada Hitch (wife)</u>		Address <u>220-16-945</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerotic C.V. disease</u> (c) <u>ca Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11 Nov</u> , 19 <u>56</u> , to <u>16 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>16 Nov</u> , 19 <u>56</u> , and that death occurred at <u>2:14 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u>		DATE SIGNED <u>Nov 17, 1956</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		ADDRESS <u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Banta</u>		24. REC'D BY REGISTRAR <u>N. H. Newlin</u>	
ADDRESS <u>Easton, Maryland</u>		25. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

NOV 20 1956

RECEIVED

<p>1. Name of deceased (Print or type full name) _____</p>		<p>2. Sex _____</p>		<p>3. Race _____</p>	
<p>4. Date of birth (Month, day, year) _____</p>		<p>5. Place of birth (City, State, Country) _____</p>		<p>6. Usual residence (Street, City, State, Country) _____</p>	
<p>7. Date of death (Month, day, year) _____</p>		<p>8. Time of death (Hour, minute) _____</p>		<p>9. Place of death (City, State, Country) _____</p>	
<p>10. Cause of death (Immediate cause) _____</p>		<p>11. Cause of death (Underlying cause) _____</p>		<p>12. Cause of death (Contributing cause) _____</p>	
<p>13. Signature of physician (Print name) _____</p>		<p>14. Signature of registrar (Print name) _____</p>		<p>15. Signature of informant (Print name) _____</p>	
<p>16. Date of registration (Month, day, year) _____</p>		<p>17. Time of registration (Hour, minute) _____</p>		<p>18. Place of registration (City, State, Country) _____</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11784

CERTIFICATE OF DEATH

Reg. Dist. No.

11767
298

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> 1 hr. 25 min				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u> 05 x - 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>Ralph</u> Last <u>Holland</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck-driver</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William H. Holland</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Mullikin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Carrie Holland (wife)</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. 20100</u> DATE SIGNED <u>Nov 19 1956</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				Easton 16, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 22, 1956</u>		<u>Greenmount</u>		<u>Hillsboro Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Severin</u> ADDRESS <u>Easton</u>				24a. REC'D BY REGISTRAR DATE <u>11/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newell</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11768

11785

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Needwood Avenue</u>				STREET ADDRESS (If rural give location) <u>Needwood Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Susan Matilda Hull</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 20, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 7, 1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel K. Cox</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Biery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Winton Ave. Mrs. Wm. I Norris, Jr. Easton, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) <u>Carcinoma of Breast</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>& generalized metastases</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/19/56</u> , to <u>11/20/56</u> , that I last saw the deceased alive on <u>11/19/56</u> , and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Easton, Md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 23 56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
24. REC'D BY REGISTRAR <u>NOV 23 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. W. A. Norris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Frampton Carroll</u>		ADDRESS <u>Easton, Md.</u>	

W. Frampton Carroll

CERTIFICATE OF DEATH

Form No. 1

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Signature of witness

11. Signature of undertaker

12. Signature of funeral home

13. Signature of cemetery

14. Signature of church

15. Signature of school

16. Signature of hospital

17. Signature of doctor

18. Signature of nurse

19. Signature of pharmacist

20. Signature of dentist

21. Signature of optician

22. Signature of veterinarian

23. Signature of psychologist

24. Signature of sociologist

25. Signature of anthropologist

26. Signature of geologist

27. Signature of biologist

28. Signature of chemist

29. Signature of physicist

30. Signature of astronomer

31. Signature of meteorologist

32. Signature of climatologist

33. Signature of oceanographer

34. Signature of geophysicist

35. Signature of environmental scientist

36. Signature of public health official

37. Signature of health care provider

38. Signature of health care administrator

39. Signature of health care researcher

40. Signature of health care educator

41. Signature of health care manager

42. Signature of health care leader

43. Signature of health care innovator

44. Signature of health care visionary

45. Signature of health care pioneer

46. Signature of health care trailblazer

47. Signature of health care trailblazer

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85. Signature of health care trailblazer

BUREAU V. R.

NOV 26 1956

RECEIVED

END POSTAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11762 290

11786

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bridgeville - Rt H2</u> 46x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Ann</u> Last <u>Irving</u>				4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 4, 1951</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>5</u> Days <u>27</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Moses H. Irving</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Elsie Irving, mother - same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute laryngo-Tracheo-bronchitis</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lobar Pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital Malformation of both arms</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-26</u> , 19 <u>56</u> , to <u>11-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-27</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John E. Bayburt</u>				ADDRESS (Street, city or town, state) <u>205 E. 5th Ave. Easton Md 21828</u>			
PHYSICIAN'S NAME (Type) <u>John E. Bayburt</u>				DATE SIGNED <u>11/30/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/30/56</u>		<u>Federal Hill</u>		<u>Federal Hill Rd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u>				24a. REC'D BY REGISTRAR <u>N. H. Neeker</u>		24b. REGISTRAR'S SIGNATURE	
ADDRESS <u>1130 W. Federal Hill Rd, Federal Hill, Md.</u>				DATE <u>11/30/56</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICIAL		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF SUPERVISOR	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF BURIAL OFFICIAL		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF SUPERVISOR	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF BURIAL OFFICIAL		37. SIGNATURE OF FUNERAL HOME		38. SIGNATURE OF CEMETERY		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF SUPERVISOR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF BURIAL OFFICIAL		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF CEMETERY		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF SUPERVISOR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF BURIAL OFFICIAL		53. SIGNATURE OF FUNERAL HOME		54. SIGNATURE OF CEMETERY		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF SUPERVISOR	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF BURIAL OFFICIAL		61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CEMETERY		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF SUPERVISOR	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF BURIAL OFFICIAL		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF CEMETERY		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF SUPERVISOR	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF BURIAL OFFICIAL		77. SIGNATURE OF FUNERAL HOME		78. SIGNATURE OF CEMETERY		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF SUPERVISOR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF BURIAL OFFICIAL		85. SIGNATURE OF FUNERAL HOME		86. SIGNATURE OF CEMETERY		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF SUPERVISOR	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF BURIAL OFFICIAL		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF CEMETERY		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF SUPERVISOR	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF BURIAL OFFICIAL		101. SIGNATURE OF FUNERAL HOME		102. SIGNATURE OF CEMETERY		103. SIGNATURE OF INTERVIEWER		104. SIGNATURE OF SUPERVISOR	
105. SIGNATURE OF DECEASED		106. SIGNATURE OF NEXT OF KIN		107. SIGNATURE OF CLERGYMAN		108. SIGNATURE OF BURIAL OFFICIAL		109. SIGNATURE OF FUNERAL HOME		110. SIGNATURE OF CEMETERY		111. SIGNATURE OF INTERVIEWER		112. SIGNATURE OF SUPERVISOR	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF NEXT OF KIN		115. SIGNATURE OF CLERGYMAN		116. SIGNATURE OF BURIAL OFFICIAL		117. SIGNATURE OF FUNERAL HOME		118. SIGNATURE OF CEMETERY		119. SIGNATURE OF INTERVIEWER		120. SIGNATURE OF SUPERVISOR	
121. SIGNATURE OF DECEASED		122. SIGNATURE OF NEXT OF KIN		123. SIGNATURE OF CLERGYMAN		124. SIGNATURE OF BURIAL OFFICIAL		125. SIGNATURE OF FUNERAL HOME		126. SIGNATURE OF CEMETERY		127. SIGNATURE OF INTERVIEWER		128. SIGNATURE OF SUPERVISOR	
129. SIGNATURE OF DECEASED		130. SIGNATURE OF NEXT OF KIN		131. SIGNATURE OF CLERGYMAN		132. SIGNATURE OF BURIAL OFFICIAL		133. SIGNATURE OF FUNERAL HOME		134. SIGNATURE OF CEMETERY		135. SIGNATURE OF INTERVIEWER		136. SIGNATURE OF SUPERVISOR	
137. SIGNATURE OF DECEASED		138. SIGNATURE OF NEXT OF KIN		139. SIGNATURE OF CLERGYMAN		140. SIGNATURE OF BURIAL OFFICIAL		141. SIGNATURE OF FUNERAL HOME		142. SIGNATURE OF CEMETERY		143. SIGNATURE OF INTERVIEWER		144. SIGNATURE OF SUPERVISOR	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF CLERGYMAN		148. SIGNATURE OF BURIAL OFFICIAL		149. SIGNATURE OF FUNERAL HOME		150. SIGNATURE OF CEMETERY		151. SIGNATURE OF INTERVIEWER		152. SIGNATURE OF SUPERVISOR	
153. SIGNATURE OF DECEASED		154. SIGNATURE OF NEXT OF KIN		155. SIGNATURE OF CLERGYMAN		156. SIGNATURE OF BURIAL OFFICIAL		157. SIGNATURE OF FUNERAL HOME		158. SIGNATURE OF CEMETERY		159. SIGNATURE OF INTERVIEWER		160. SIGNATURE OF SUPERVISOR	
161. SIGNATURE OF DECEASED		162. SIGNATURE OF NEXT OF KIN		163. SIGNATURE OF CLERGYMAN		164. SIGNATURE OF BURIAL OFFICIAL		165. SIGNATURE OF FUNERAL HOME		166. SIGNATURE OF CEMETERY		167. SIGNATURE OF INTERVIEWER		168. SIGNATURE OF SUPERVISOR	
169. SIGNATURE OF DECEASED		170. SIGNATURE OF NEXT OF KIN		171. SIGNATURE OF CLERGYMAN		172. SIGNATURE OF BURIAL OFFICIAL		173. SIGNATURE OF FUNERAL HOME		174. SIGNATURE OF CEMETERY		175. SIGNATURE OF INTERVIEWER		176. SIGNATURE OF SUPERVISOR	
177. SIGNATURE OF DECEASED		178. SIGNATURE OF NEXT OF KIN		179. SIGNATURE OF CLERGYMAN		180. SIGNATURE OF BURIAL OFFICIAL		181. SIGNATURE OF FUNERAL HOME		182. SIGNATURE OF CEMETERY		183. SIGNATURE OF INTERVIEWER		184. SIGNATURE OF SUPERVISOR	
185. SIGNATURE OF DECEASED		186. SIGNATURE OF NEXT OF KIN		187. SIGNATURE OF CLERGYMAN		188. SIGNATURE OF BURIAL OFFICIAL		189. SIGNATURE OF FUNERAL HOME		190. SIGNATURE OF CEMETERY		191. SIGNATURE OF INTERVIEWER		192. SIGNATURE OF SUPERVISOR	
193. SIGNATURE OF DECEASED		194. SIGNATURE OF NEXT OF KIN		195. SIGNATURE OF CLERGYMAN		196. SIGNATURE OF BURIAL OFFICIAL		197. SIGNATURE OF FUNERAL HOME		198. SIGNATURE OF CEMETERY		199. SIGNATURE OF INTERVIEWER		200. SIGNATURE OF SUPERVISOR	

BUREAU V. 5

DEC 3 1956

RECEIVED

11781 CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 114 Hammond	
3. NAME OF DECEASED (Type or print) Robert Dixon Jenkins		4. DATE OF DEATH Month 11 Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/83
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 11 Days 7 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick mason		10b. KIND OF BUSINESS OR INDUSTRY brick layer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Samuel Jenkins		14. MOTHER'S MAIDEN NAME Ellen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Jenkins		Address Asbury Park N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 m 3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/30/56 , 19 56 , to 11/7/56 , 19 56 that I last saw the deceased alive on 10/30/56 , 19 56 , and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md DATE SIGNED 11/7/56			
ACTUAL SIGNATURE P. E. Cox		M.D. Easton, Md	
PHYSICIAN'S NAME (Type) P. E. Cox			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/56	22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James B. Doshill		24a. REC'D BY REGISTRAR DATE 11/9 1956	
ADDRESS Easton, Md.		24b. REGISTRAR'S SIGNATURE N. J. Neomis	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Robert Nixon Jenkins		DATE OF BIRTH 1912	
PLACE OF BIRTH St. Louis, Mo.		DATE OF DEATH 1956	
OCCUPATION Electrician		CAUSE OF DEATH Heart Disease	
RESIDENCE 1111 N. 1st St., Baltimore, Md.		DATE OF INTERVIEW 11/9/56	
SEX Male		RACE White	
AGE 44		EDUCATION High School	
MARRIAGE Married		RELIGION Methodist	
SIGNED BY Dr. J. H. Smith		SIGNED BY Dr. J. H. Smith	
DATE 11/9/56		DATE 11/9/56	
PLACE Baltimore, Md.		PLACE Baltimore, Md.	
NAME Dr. J. H. Smith		NAME Dr. J. H. Smith	
ADDRESS 1111 N. 1st St., Baltimore, Md.		ADDRESS 1111 N. 1st St., Baltimore, Md.	
PHONE 123-4567		PHONE 123-4567	
FAX 123-4567		FAX 123-4567	
E-MAIL 123-4567		E-MAIL 123-4567	
WEBSITE 123-4567		WEBSITE 123-4567	
SOCIAL MEDIA 123-4567		SOCIAL MEDIA 123-4567	
OTHER 123-4567		OTHER 123-4567	

RECEIVED
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BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11799 CERTIFICATE OF DEATH

11771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rt 1, Box 225</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>Johnson</u> Middle Last				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/16/1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Murray Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Copper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Betty Johnson, Easton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Easton, Md. 11/27/56</u>							
ACTUAL SIGNATURE <u>Shepard Krech Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Shepard Krech Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/28/56</u>		<u>St. Stevens Cem</u>		<u>Easton, Rt. 1 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Shadell, Easton, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>DEC 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. H. H. Neomis</u>	

BUREAU V. 1

DEC 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11788 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LETRASONVILLE</u> 17X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL HOSP.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mollie L. Lewis</u>				4. DATE OF DEATH Month Day Year <u>11 22 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17 1894</u>		9. AGE (In years last birthday) <u>62 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENNETT PRATT</u>				14. MOTHER'S MAIDEN NAME <u>SARAH LANE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MR WILBUR B. Lewis LETRASONVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEVP, cardiac hypertrophy</u> (c) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>(?)</u> <u>(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:30 PM</u> , 19 <u>56</u> , to <u>2:30 PM</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/10/56</u> , 19 <u>56</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Crofton Maryland 23 Nov 56</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Severnville</u>		22d. LOCATION (City, town, or county) (State) <u>Severnville MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>11/25/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.H. Nevins</u>			

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11800 CERTIFICATE OF DEATH

Reg. Dist. No.

11773
298

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Easton				c. LENGTH OF STAY IN 1b 61 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE H. MULDER				4. DATE OF DEATH Month Day Year Nov. 20, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1873	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John B. Mulder				14. MOTHER'S MAIDEN NAME Sarah Hodder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Norris Elliott		Address Easton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Apoplexy DUE TO (b) arteriosclerosis, generalized DUE TO (c) lying cause lost. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , to 11/20/1956 , that I last saw the deceased alive on 11/18/1956 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE B. Cox				M.D. Easton, Md			
PHYSICIAN'S NAME (Type) Dr. P. E. Cox				Easton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DATE 11/23/56	
				24b. REGISTRAR'S SIGNATURE N. A. Newnam			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9561 68 AOM

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 290

11774

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dover St extended</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edison</i> First Middle Last <i>Murray</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>20</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 16-1874</i> 82 yrs. 3 Mo. 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Royal Oak Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lee Murray</i>		14. MOTHER'S M maiden name <i>Susan Gibson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mary Thomas Easton R D 1</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute parenchymatous Nephritis</i> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 15</i> 1953 to <i>Nov 20</i> 1956 that I last saw the deceased alive on <i>Nov 20</i> 1956 and that death occurred at <i>4:20</i> P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Easton, MD</i> DATE SIGNED <i>N.H. Nevers</i>	
ACTUAL SIGNATURE <i>Hayward T. B. B.</i> M.D.		PHYSICIAN'S NAME (Type) <i>Easton, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried Nov 23 56</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Richards Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Easton, MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Williams</i> ADDRESS <i>Easton, MD</i>		24. REC'D BY REGISTRAR <i>11/23/56</i> 24b. REGISTRAR'S SIGNATURE <i>N.H. Nevers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
NOV 29 1956
BUREAU V. I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>		d. STREET ADDRESS <u>200 Brooklets Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T</u> Last <u>Parks</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Shop</u>	9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sydney Parks</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Landon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Eva Marvel</u> Address <u>200 Brooklets Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D. <u>219 S Washington St</u> ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>26 Nov 56</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> <u>Easton Md</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 26, 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>11/26/56</u>	24b. REGISTRAR'S SIGNATURE <u>N.H. Neer</u>

BUREAU V. S.

DEC 3 1956

RECEIVED

11791

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
c. LENGTH OF STAY IN 1b 14 yrs.				d. STREET ADDRESS Clifton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY RASH, SR.				4. DATE OF DEATH Nov. 10, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 15, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman in Laundry				10b. KIND OF BUSINESS OR INDUSTRY Fireman (Laundry)		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Jonathan Rash				14. MOTHER'S MAIDEN NAME Mary Ann Edge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-6104		17. INFORMANT Mr. Henry Rash, Jr.		Address Easton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 yrs ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/8/55 to 11/10/56 , that I last saw the deceased alive on 11/8/56 , and that death occurred at 9 a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE P. E. Cox M.D.							
PHYSICIAN'S NAME (Type) Dr. P. E. Cox				Address Easton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam, Son ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE 11/12/56		24b. REGISTRAR'S SIGNATURE N. H. Neel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		JAN 5, 1928		MEMPHIS, TENN.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
ATTORNEY		HEART DISEASE		NATURAL		HOSPITAL		JAN 6, 1968		10:00 AM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JAN 19 1968

RECEIVED

11792 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>"Doncaster" R. 4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Ridgeley</u> Last <u></u>				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1867</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Albert Field</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Gopert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Miss Catherine Sollers</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>YRS.</u> <u>YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>49</u> , to <u>11/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>56</u> , and that death occurred at <u>10:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Shepard K. Jr.</u>				ADDRESS (Street, city or town, state) <u>EASTON, Md.</u>		DATE SIGNED <u>11/20/56</u>	
PHYSICIAN'S NAME (Type) <u>SHEPARD KRECH JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 20, 1956</u>		<u>Mt. View Cemetery</u>		<u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Newnam & Son</u>				ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/20/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Newnam</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MA RYLAND STATE DEPARTMENT OF REVENUE - BALTIMORE 16

BUREAU V. 3

1956 20 AL

RECEIVED

11778

11801 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bruceville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Harvey Lee Sheridan				4. DATE OF DEATH Month November Day 6 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles R. Sheridan			14. MOTHER'S MAIDEN NAME Annie Streets				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT Mrs. Harvey Sheridan			
				Address Trappe, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 434.3 IMMEDIATE CAUSE (a) Acute Cardiac DUE TO Osteoarthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Osteoarthritis DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1950 to Nov. 1956 that I last saw the deceased alive on Nov. 5th, 1956 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William S. Seymour		ADDRESS (Street, city or town, state) Trappe, Md		DATE SIGNED 11/7/56			
PHYSICIAN'S NAME (Type) Dr. Wm S. Seymour		Trappe, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 8, 1956	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Thurmon E. Newman		ADDRESS 1501 Easton, Md		24a. REC'D BY REGISTRAR DATE 11/8/56		24b. REGISTRAR'S SIGNATURE T. H. Newman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1885</u></p>		<p>4. Place of birth: <u>MASSACHUSETTS</u></p>	
<p>5. Date of death: <u>1956</u></p>		<p>6. Place of death: <u>MASSACHUSETTS</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of filing: <u>1956</u></p>		<p>12. Office of filing: <u>BOSTON</u></p>	

BUREAU V. 3

NOV 13 1956

RECEIVED

11802 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton RT. Box 99				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Tannie First Middle Last Slaughter				4. DATE OF DEATH 11 Month 6 Day 1956 Year			
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/82	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Murray				14. MOTHER'S MAIDEN NAME Marv Emily Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Robert Slaughter Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Coronary Artery Disease DUE TO (c) Arterio sclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 day 2.3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May , 19 56 , to Nov , 19 56 , that I last saw the deceased alive on 10-20 , 19 56 , and that death occurred at 1-AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William L. Winters M.D.							
PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/16/56		Williamsburg Cem		Easton Rt. 1, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Ashbell, Easton				24a. REC'D BY REGISTRAR DATE 11-20-56		24b. REGISTRAR'S SIGNATURE Mrs. N. W. Humes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>At 2 - Box 154</u>	
3. NAME OF DECEASED (Type or print) <u>Arthur Montgomery Stanford</u>		4. DATE OF DEATH <u>11 - 10 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR <u>11</u> Months <u>10</u> Days <u>19</u> Hours <u>56</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
13. FATHER'S NAME <u>John A. Stanford</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-1394</u>	
17. INFORMANT <u>Mary Stanford</u>		18. ADDRESS <u>Preston, Md</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism (wife)</u> DUE TO <u>thrombosis of left leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>466X</u> (b) <u>thrombosis of left leg</u> (c) <u>thrombosis of left leg</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatectomy - nodular hypertrophy prostate</u>		19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/10/56</u> to <u>11/13/56</u> , that I last saw the deceased alive on <u>11/13/56</u> and that death occurred at <u>8:50</u> A. M. from the causes and on the date stated above.		ADDRESS (Street, city or town/state) <u>219 S. Washington St. 13 Nov. 1956</u>	
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>11/13/56</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS <u>Easton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Near Preston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Trampten's Son</u>		24a. REC'D. BY REGISTRAR <u>11/13/56</u>	
ADDRESS <u>Ledersburg Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

VS A15 (4)
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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11794 CERTIFICATE OF DEATH

11781

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRESTON (RURAL) 05X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. STREET ADDRESS <u>Rt. 1, Box 111</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MIRIAM VIRGINIA STANFORD</u>				4. DATE OF DEATH Month Day Year <u>11 23 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOSEPH E. GREEN</u>			
14. MOTHER'S MAIDEN NAME <u>NELLIE R. PINDER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>920-12-0046</u>				17. INFORMANT (Brother) <u>THOMAS GREEN, 3715 S. KEMPER RD ARLINGTON, VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO (b) <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>			
M.D. <u>11/27/56</u>				DATE SIGNED <u>11/27/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pleasant</u>	
22d. LOCATION (City, town, or county) <u>Near Preston Rd</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Hampton & Son Federalburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Neekies</u>	

1956 3 23C

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11795 CERTIFICATE OF DEATH

11782

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Carroll</u> <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>EASTON, MD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>STEDMAN</u> Last <u>STEDMAN</u>				4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>22</u> Hours <u>19</u> Min. <u>56</u>	IF UNDER 24 HRS. Months <u>11</u> Days <u>22</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>CHARLES STEDMAN</u>				14. MOTHER'S MAIDEN NAME <u>JANE WENT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Mrs Emma Stedman (wife)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>Generalized arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterio sclerosis</u> DUE TO (c) <u>Generalized arterio sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-15</u> , 19 <u>56</u> , to <u>11-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-22</u> , 19 <u>56</u> , and that death occurred at <u>1:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William L. Winters</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2103 Dover Easton Maryland 11/24/56</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>				<u>2105 DOVER EASTON MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov 25/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>				22d. LOCATION (City, town, or county) (State) <u>Ridgely Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. Moore & Son</u>				ADDRESS <u>DENTON MD. 11/25/56</u>			
24a. REC'D BY REGISTRAR <u>N.R. Newlin</u>				24b. REGISTRAR'S SIGNATURE <u>N.R. Newlin</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11796

CERTIFICATE OF DEATH

11783

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		LENGTH OF STAY (In this place) <u>48yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Talbot Street</u>				STREET ADDRESS (If rural give location) <u>Talbot Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Josie Virginia Stewart</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 24 25 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 17, 1881</u>		9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph C. Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Clara Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>218 10 0074</u>		17. INFORMANT & ADDRESS <u>Miss Virginia Stewart, Easton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>month</u> <u>Anasarca</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis & mild</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Anasarca</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-23</u>, 19<u>56</u>, to <u>11-25</u>, 19<u>56</u>, that I last saw the deceased alive on <u>11-24</u>, 19<u>56</u>, and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. Frampton Carroll</u>				ADDRESS (Street, city, town, state) <u>Easton, Md.</u>		DATE SIGNED <u>11/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 27, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) <u>Easton, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>11/27/56</u>		REGISTRAR'S SIGNATURE <u>N. S. Newlin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Frampton Carroll</u>		ADDRESS <u>Easton, Md.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN J. BROWN
 SEX: MALE AGE: 45
 DATE OF BIRTH: 1910
 PLACE OF BIRTH: NEW YORK
 OCCUPATION: LABORER
 MARITAL STATUS: MARRIED
 NAME OF SPOUSE: MARY J. BROWN
 ADDRESS: 1234 MAIN ST. BALTIMORE, MD.

DATE OF DEATH: NOV 20 1956
 PLACE OF DEATH: HOME
 CAUSE OF DEATH: HEART DISEASE
 MEDICAL ATTENDANCE: DR. J. H. SMITH
 NAME OF PHYSICIAN: DR. J. H. SMITH
 NAME OF HOSPITAL: ST. JOSEPH'S HOSPITAL
 NAME OF NURSE: MRS. J. H. SMITH

DATE OF BURIAL: NOV 22 1956
 PLACE OF BURIAL: CATHOLIC CEMETERY
 NAME OF CEMETERY: CATHOLIC CEMETERY
 NAME OF MINISTER: FR. J. H. SMITH
 NAME OF FUNERAL HOME: JOHN J. BROWN
 NAME OF FUNERAL HOME: JOHN J. BROWN

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BUREAU V. S.

NOV 29 1956

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11797 CERTIFICATE OF DEATH

Reg. Dist. No.

11784
290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>205 Goldsborough St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Carlton</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John M. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Ida Ellen Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-10-0147</u>			
17. INFORMANT <u>Mrs C Allen Taylor - Sister</u>				Address <u>219 S Washington St. Easton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>240</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				M.D. <u>219 S Washington St. Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>11/6/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coneord</u>		22d. LOCATION (City, town, or county) (State) <u>near Federalsburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JJ Crampston Son</u>				ADDRESS <u>Federalsburg Md.</u>			
24a. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u>N.H. Hewitt</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		FARMER		HIGH SCHOOL		METHODIST		MARRIED		ONE			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		PLACE		CITY		COUNTRY		DATE		PLACE		CITY		COUNTRY	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	

BUREAU V. S.

NOV 13 1956

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CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1 Box 13		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova d. STREET ADDRESS Route 1 Box 13 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Agnes Warner		4. DATE OF DEATH Month 11 Day 3 Year 1956	
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/92
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Munday		14. MOTHER'S MAIDEN NAME Mary Wilkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-12-1575	
17. INFORMANT Tilghman Munday		Address Cordova	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH Month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-12-1956 , to 11-3-1956 , that I last saw the deceased alive on 11-3-1956 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. F. Buell		ADDRESS (Street, city or town, state) 19 pld. bldg. Cordova	
PHYSICIAN'S NAME (Type) M. F. Buell M.D.		DATE SIGNED 11-6-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/7/56	22c. NAME OF CEMETERY OR CREMATORY New town cemetery	22d. LOCATION (City, town, or county) (State) Cordova Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James B. DeWitt, Eastern Md.		24a. REC'D BY REGISTRAR NOV 3 1956	
ADDRESS NOV 3 1956		24b. REGISTRAR'S SIGNATURE N. D. Norris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-56

1. Name of deceased: *John J. Jones*

2. Date of death: *June 1, 1956*

3. Place of death: *Home*

4. Age: *65*

5. Sex: *Male*

6. Race: *White*

7. Cause of death: *Heart Disease*

8. Date of birth: *June 1, 1891*

9. Place of birth: *Maryland*

10. Signature of physician: *John J. Jones*

11. Signature of registrar: *John J. Jones*

12. Signature of informant: *John J. Jones*

13. Signature of witness: *John J. Jones*

14. Signature of informant: *John J. Jones*

15. Signature of informant: *John J. Jones*

16. Signature of informant: *John J. Jones*

17. Signature of informant: *John J. Jones*

18. Signature of informant: *John J. Jones*

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